

CURRENT HEALTH

What are the main symptoms/problems you seek treatment for, and how long have you had them?

Diagnoses you've been given by physicians: _____

In the past 12 months have you required?

Hospitalization? Yes No # Days _____ For _____

Visits to the Emergency Room? Yes No # Visits _____ For _____

Home care services? Yes No If yes, please describe _____

Please list any previous surgeries, hospitalizations, and serious illnesses with dates:

WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

- Diabetes
- Stroke/heart attack
- Multiple sclerosis
- Epilepsy/ seizures
- Pacemaker
- Allergies to metal
- Arthritis
- Fibromyalgia
- Chronic fatigue syndrome
- Cancer: what type _____
- Other: _____
- Mental health issues: what type _____
- HIV/AIDS
- Hepatitis B
- Hepatitis C
- TB
- Allergies: what drugs or substances (plant, animal, environmental) _____

DIAGNOSTIC QUESTIONS

Please indicate all symptoms below that you have experienced **within the past 30 days**.

Please circle according to the severity of your symptoms

L=Light M=Medium S=Strong

If you do not have the symptom, do not circle anything.

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|-----------------------------|----------------------------|--------------------------|
| L M S sinus problems | L M S nose bleeds | L M S dry mouth |
| L M S difficulty swallowing | L M S sore throat/mouth | L M S thrush/leukoplakia |
| L M S headaches | L M S dental/gum | L M S thirst |
| L M S ear/hearing problems | L M S vision problems | L M S dizziness |
| L M S sneezing/runny nose | L M S other (specify)_____ | |

RESPIRATORY

- | | | |
|----------------------------|--------------------------|------------------|
| L M S shortness of breath | L M S pain w/deep breath | L M S phlegm |
| L M S blood in sputum | L M S wheezing | L M S cough |
| L M S bronchitis | L M S frequent colds | L M S chest pain |
| L M S other (specify)_____ | | |

GASTROINTESTINAL

- | | | |
|------------------------|-----------------------------|----------------|
| L M S loss of appetite | L M S abdominal cramps | L M S nausea |
| L M S gas/bloating | L M S constipation | L M S diarrhea |
| L M S weight loss | L M S hemorrhoids | L M S vomiting |
| L M S heartburn | L M S other, specify: _____ | |
| L M S jaundice | | |

CARDIOVASCULAR

- | | | |
|--------------------------|---------------------------|--------------------|
| L M S low blood pressure | L M S high blood pressure | L M S palpitations |
|--------------------------|---------------------------|--------------------|

GENITO-URINARY

- | | | |
|----------------------------|-----------------------|-----------------|
| L M S frequent urination | L M S night urination | L M S impotence |
| L M S low sex drive | L M S pain | L M S edema |
| L M S genital sores | L M S genital warts | |
| L M S other, specify _____ | | |

MUSCULAR/SKELETAL

- | | | |
|---|----------------------------|----------------|
| L M S muscle/joint pain | L M S back pain | L M S weakness |
| L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy | | |
| L M S stiff neck/shoulders | L M S other, specify _____ | |

PATHWAYS TO WELLNESS

INITIAL INTAKE FORM

NEUROLOGICAL/PSYCHOLOGICAL

- | | | |
|----------------------------|----------------------|---------------------|
| L M S depression | L M S anxiety | L M S fear |
| L M S irritability/anger | L M S disorientation | L M S forgetfulness |
| L M S tremors | L M S insomnia | L M S seizures |
| L M S poor concentration | L M S bipolar | |
| L M S other, specify _____ | | |

SKIN/HAIR/NAILS

- | | | |
|----------------------------|--------------------|------------------|
| L M S itchy/painful rashes | L M S fungus | L M S shingles |
| L M S psoriasis/eczema | L M S mole changes | L M S cold sores |
| L M S new KS | L M S hair loss | L M S acne |
| L M S bleed/bruise easily | L M S other _____ | |

OTHER SYMPTOMS

- | | | |
|---------------------------|---|------------------|
| L M S fever over 100 | L M S night sweats | L M S fatigue |
| L M S swollen lymph nodes | L M S chills | L M S day sweats |
| L M S glucose intolerance | L M S lipodystrophy/ fat redistribution | |
| L M S other _____ | | |

GYNECOLOGICAL/OBSTETRICS

- | | | |
|-------------------------|----------------------------|-------------------|
| L M S yeast infections | L M S menstrual cramps | L M S clots |
| L M S pelvic infections | L M S spotting | L M S PMS |
| L M S mid-cycle pain | L M S irregular periods | L M S no periods |
| L M S vaginal discharge | L M S vaginal pain/itching | L M S hot flashes |
| L M S Other _____ | | |

Menstrual Info: ____ days bleeding ____ day cycle date last period _____

Do you take Hormone Replacement Therapy? Yes No

Are you pregnant? Yes No Unknown

Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? Yes No Unknown

How many pregnancies have you had? _____ Cesareans? _____

Date last pap smear _____ NORMAL ABNORMAL

Last breast exam _____ NORMAL ABNORMAL

WESTERN MEDICATIONS

Please list below all of the medications/supplements/herbs you take:
 I do not take any Western medications, supplements or herbs.

<u>Medication/Supplement/Herb</u>	<u>Used to treat</u>	<u>Side-Effects Experienced</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

Adherence Level: Overall in the past month, have you taken your prescribed medications:
 Almost never Less than 50% of the time 50% of the time Routinely Unknown

Client Signature: _____ **Date:** _____

ADMINISTRATIVE USE ONLY

Referrals needed for: _____

Referrals made to: _____

Misc: _____

Reviewing Acupuncturist: _____ **Print Name:** _____

Date: _____

Weight: _____

TREATING PRACTITIONER SHOULD GENERATE TREATMENT PLAN